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99TH CONGRESS
2d Session

HOUSE OF REPRESENTATIVES

REPORT
99-710

DIRECT REIMBURSEMENT OF CERTAIN HEALTH CARE PROVIDERS UNDER THE FEDERAL EMPLOYEES' HEALTH BENEFITS PROGRAM

JULY 24, 1986.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Ms. OAKAR, from the Committee on Post Office and Civil Service, submitted the following

REPORT

[To accompany H.R. 4825]

[Including cost estimate of the Congressional Budget Office]

The Committee on Post Office and Civil Service, to whom was referred the bill (H.R. 4825) to amend chapter 89 of title 5, United States Code, to provide authority for the direct payment or reimbursement of certain additional types of health care professionals; to clarify certain provisions of such chapter with respect to coordination with State and local law; and for other purposes, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

PURPOSE

The purpose of this legislation is to require health insurance plans under the Federal Employees Health Benefits Program (FEHBP) to provide direct access to certain non-physician health care professionals who are licensed or certified under State law to provide covered health services.

COMMITTEE ACTION

On May 14, 1986, Ms. Mary Rose Oakar and five original cosponsors introduced H.R. 4825, a bill to provide for direct access to certain health care providers under the Federal Employees Health Benefits Program.

On April 15, 1986, the Subcommittee on Compensation and Employee Benefits held an oversight hearing on measures to promote

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cost-effectiveness and consumer choice within the FEHBP. Testimony was received from representatives of the Administration, representatives of physician and other health provider organizations, representatives of FEHBP plans, and other public witnesses.

On June 5, 1986, the Subcommittee on Compensation and Employee Benefits approved H.R. 4825, without amendment, for full Committee consideration. On June 11, 1986, the Committee on Post Office and Civil Service, by a record vote of 17 to 0, and with a quorum present, ordered H.R. 4825 favorably reported without amendment.

SUMMARY

H.R. 4825 amends chapter 89 of title 5, United States Code, to provide for direct access to certain non-physician health practitioners who provide covered services under the Federal Employees Health Benefits Program (FEHBP).

The bill provides that FEHBP participants shall have direct access to qualified nurse practitioners, nurse-midwives, nurses, clinical social workers, marriage and family therapists, and chiropractors, without supervision or referral by another health practitioner, except if, or to the extent that, such supervision or referral is required under any State or local law or any regulation issued thereunder, which relates to licensing or certification to practice medicine, nursing, or another health profession. These health practitioners must be licensed or certified as such under Federal or State law, as applicable.

Payment or reimbursement for the services of these health practitioners shall be made under the same terms and conditions as are generally applicable under FEHBP contracts requiring payment or reimbursement for the services of other health practitioners covered under existing law. It is not the intent of this legislation to require FEHBP plans to cover any and all services provided by health practitioners. Rather, the intent is only to require that FEHBP plans allow their subscribers to choose an appropriate health professional, subject to State or local licensing or certification laws, to provide covered services.

The direct access provisions of H.R. 4825 shall not apply to prepayment plans described in section 8903(4) of title 5, United States Code.

The bill provides that it is the intent of Congress that nothing in this legislation shall interfere with applicable institutional anesthesia practice rules or State or local laws governing supervision of a certified registered nurse anesthetist (CRNA) by another health practitioner. In addition, it is the intent of Congress that this provision, as it relates to CRNAs, shall apply only with respect to CRNAs who are self-employed and licensed or certified under Federal or State law, as applicable. Regulations issued under this legislation shall reflect the Congressional intent as described above.

H.R. 4825 provides that nothing in chapter 89 nor in FEHBP contracts shall supersede or preempt any State or local law or regulation issued thereunder relating to licensing or certification to practice medicine, nursing, or another health profession.

While plans may, under existing law, require psychiatric referral as a requirement for reimbursement of qualified clinical social workers practicing in states which do not license such practitioners, any such referral requirements shall not be enforceable in states designated as medically underserved areas as described in section 8902(m)(2)(A) of title 5, United States Code.

The amendments made by H.R. 4825 shall be effective with respect to contracts entered into or renewed for calendar years beginning after the date of enactment.

STATEMENT

Freedom of choice is an important characteristic of the Federal Employees Health Benefits Program (FEHBP), the largest employer-sponsored group health insurance program in the country, serving some 10 million Federal employees, retirees, and their dependents. An array of over 20 government-wide health insurance plans and almost 300 regional health maintenance organizations (HMOs) participating in the FEHBP contribute greatly to such freedom of choice.

Within fee-for-service plans, however, FEHBP enrollees may find their options limited when selecting a health care provider. Current law enables fee-for-service plans in the FEHBP to restrict or deny reimbursement to most non-physician practitioners, thereby narrowing an enrollee's freedom of choice among providers.

The committee believes that a greater choice among health care provider will promote cost effectiveness within the FEHBP. Often, non-physician providers charge fees lower than those of physicians. Furthermore, when insurance plans impose their own requirements of physician supervision or referral for certain providers, in addition to any such requirements imposed by law, the plans may be incurring unnecessary costs or discouraging subscribers from seeking lower cost health care.

The committee also believes that requiring direct access to a wider choice of health care providers will increase the likelihood that FEHBP enrollees will be able to find the health care they need. This is especially crucial in areas of mental health care and preventive health care, in which Federal employees' health needs may not always be met.

It is important to draw the distinction between mandatory direct access to certain health care providers and mandatory coverage of certain health care services under the FEHBP. Direct access to health care providers will enable FEHBP beneficiaries to take full advantage of their existing insurance coverage for health services. With mandatory direct access, FEHBP enrollees will be better able to seek out the health care provider they prefer and whose services are affordable and convenient.

Nevertheless, the committee recognizes that limits on coverage within FEHBP plans might still prevent enrollees from receiving all the care they want or need. Questions have been raised as to whether a direct access requirement will serve to expand current insurance coverage or mandate new health insurance benefits in order to meet these needs. It will not. The issue of mandatory health benefits is completely separate from the issue of mandatory

access to health care providers. Direct access requirements are intended to increase freedom of choice, not utilization or services or scope of insurance coverage.

For example, the committee acknowledges that marital and family therapy already is a well recognized treatment modality which is practiced by many mental health professionals, including psychiatrists, who are already covered under the FEHBP. Marital and family therapy is a respected and widely used treatment for substance abuse disorders, chemical dependency, anorexia, schizophrenia, and many other major mental illnesses. Qualified marital and family therapists provide expert, necessary therapeutic services that are both cost-efficient and effective. By providing reimbursement for treatment by qualified marital and family therapists on the same basis as that provided for treatment by psychiatrists and psychologists, the FEHBP would allow its participants wider access to needed services already included as health benefits within their program.

Precedents for requiring direct access to non-physician health care providers have been established. Federal law requires that FEHBP plans reimburse non-physician providers for covered services rendered to participants who live in medically underserved areas (MUAs). In addition, since 1973, Federal law has required that FEHBP participants have direct access to psychologists and to optometrists. Finally, the military's health insurance program, CHAMPUS, requires that its enrollees have direct access to a number of non-physician health care providers.

On December 19, 1985, Congress passed H.R. 3384, legislation to provide for a number of reforms in the FEHBP, including mandatory direct reimbursement of nurses and nurses-midwives. The President vetoed H.R. 3384, stating in part,

> . . . the provision requiring direct access to and permitting direct payment for the services of nurses and nurse-midwives, without supervision or referral by another health practitioner, deserves full evaluation, including hearings by the Congress. In its present form, it is a major departure from established health care practice and may be counter to many State laws.

Accordingly, Congress passed H.R. 4061 (P.L. 99-251), requiring the Office of Personnel Management (OPM) to study the feasibility of direct access under the FEHBP. On March 31, 1986, OPM presented the results of its study to the Subcommittee on Compensation and Employee Benefits. The OPM study found that many FEHBP carriers already offer direct access to non-physician providers. Furthermore, OPM found no evidence that a program-wide policy of direct access would reduce the quality of care, or decrease competition between plans, within the FEHBP. OPM's conclusion with respect to the likely effects of a direct access policy on FEHBP costs were most emphatic:

> Historically, OPM and its predecessor agency, the Civil Service Commission, along with most of the major insurance carriers, have argued that mandating coverage of additional categories of providers would lead inevitably to an

> increase in utilization and, hence, drive up Program costs. . . . With the possible exception of mandatory coverage of chiropractors, OPM can no longer support this view. The adverse consequences foreseen in 1973 in connection with mandating coverage for optometrists and psychologists proved largely chimerical. Under the [Medically Underserved Areas] experiment, increased utilization, except in the case of chiropractors, was insignificant. Further, there is the incontestable fact that alternative providers have been recognized under many of our plans for a considerable period of time now, not only without adverse consequences, but in some cases with beneficial ones.
>
> Opponents of extending coverage argue that elaborate cost benefit studies should be performed before we embark on the potentially dangerous course of mandatory recognition of non-traditional providers. While it would indeed be a comfort to have such studies in hand, we cannot measure the consequences until and unless we take the step. What we do know is that the limited steps mandated in the past and the voluntary actions we have taken have not had deleterious consequences for the Program.

With respect to chiropractors, the OPM study noted:

> OPM's own experience under the MUA experiment indicates that mandatory recognition of chiropractors would increase utilization of their services. We are able to document an increase of .0005 percent in the medically underserved States when the MUA amendment was in effect in 1983. Unfortunately, we do not know whether that increase in costs was accompanied to any degree by a decrease in the utilization of physician providers.

On April 15, 1986, the Subcommittee on Compensation and Employee Benefits held a hearing on the issue of direct access to non-physician health care providers. Many witnesses provided information relating to the quality of health care provided by non-physician professionals, the cost of care, and the feasibility and desirability of requiring direct access to such professionals. As a result of this hearing, a number of issues were raised which are addressed in H.R. 4825.

QUALITY OF CARE/STATE LICENSING LAWS

The committee is determined to maintain the quality of health care under the FEHBP. Any change in the Program must be evaluated against the likely effects on the quality of care for Federal employees, annuitants, and their families. During the subcommittee hearing, representatives of physician and non-physician provider groups testified that State licensure requirements are key to ensuring that health care professionals provide quality care. Witnesses states that licensed nurse-practitioners, clinical social workers, certified nurse-midwives, chiropractors, marriage and family therapists, and other professionals are well qualified to offer the services they provide.

Federal law already requires that FEHBP providers meet State licensure or certification requirements in order to be reimbursed. Current law, for example, requires that FEHBP enrollees have direct access to clinical psychologists and optometrists, "licensed or certified as such under Federal or State law, as applicable," without supervision or referral by another health practitioner. Consequently, the amendments made by section 1 of H.R. 4825 require that FEHBP enrollees shall have direct access to chiropractors, qualified clinical social workers, marriage and family therapists, nurse midwives, nurse practitioners, and any other nurses who are licensed or certified as such under Federal or State law, as applicable.

During the subcommittee hearing, however, the OPM recommended that Federal law recognize the importance of such State licensing laws more specifically because Federal law also requires that FEHBP contract provisions shall supersede and preempt State or local law relating to health insurance. The OPM recommendation was based upon the President's message accompanying the veto of H.R. 3384, which raised questions as to the applicability of State licensing laws with respect to FEHBP contracts. To avoid confusion about the Federal preemption provision, OPM recommended that the Federal law be clarified to specify that FEHBP contracts do not override State licensing laws.

Consequently, the amendments made by section 2 of H.R. 4825 provide that FEHBP contracts shall not supersede or preempt any State or local law, or any regulation issued thereunder, which relates to licensing or certification to practice medicine, nursing, or another health profession. In addition, the bill provides that participants shall have direct access to chiropractors, qualified clinical social workers, marriage and family thereapists, nurse practitioners, nurse-midwives, and any other nurse, without supervision or referral by another health practitioner, "except if, or to the extent that, any such supervision or referral is required under State or local law, or any regulation issued thereunder," which relates to licensing or certification to practice medicine, nursing, or another health profession.

Section 1 of H.R. 4825 amends section 8902(k)(1) of title 5, United States Code, relating to psychologists and optometrists, to provide language parallel to the new subsection (k)(2) requiring direct access to chiropractors, qualified clinical social workers, marriage and family therapists nurse midwives, nurse practitioners, and any other nurses. The committee recognizes that psychologists and optometrists are licensed in all 50 States and in the District of Columbia to practice without supervision or referral by another health care practitioner. The committee emphasizes that the new reference to State or local law in 8902(k)(1) does not change, and is not intended to change, the current direct access practices for psychologists and optometrists under the FEHBP program. Rather, the new language in 8901(k)(1) is included to create parallel construction between that section and section 8902(k)(2).

COST OF HEALTH CARE

Concerns have been raised that expanding access to non-physician health care providers might increase costs to enrollees and to the Federal Government under the FEHBP. Testimony before the Subcommittee on Compensation and Employee Benefits, however, suggested that non-physician health care providers tend to charge competitive fees which are usually lower than those charged by their physician counterparts. In addition, witnesses testified that increased competition among health care providers would tend to hold down fees for all health services.

The committee was most impressed, however, by the conclusions of the OPM report on reimbursement of non-physician providers. As noted earlier, OPM reported that, based on its experience with the MUA experiment, expanded access to non-physician providers would have no adverse impact on FEHBP costs and could have beneficial effects on the program.

The OPM report did contain one exception to this conclusion with respect to chiropractors. OPM noted a slight increase (.0005 percent) in utilization of chiropractic services under the MUA experiment. However, OPM was not able to provide full data on the cost of providing direct access to these health practitioners. The committee believes that even if the cost of chiropractic services to the program should increase by .0005 percent, the benefits of expanding access to chiropractors far outweight the minimal cost increases alluded to by OPM concerning the MUA experiment.

EFFECTS OF DIRECT ACCESS ON STANDARD HEALTH CARE BILLING PRACTICES

It is the committee's intent to expand FEHBP enrollees' freedom of choice by providing direct access to certain non-physician health care providers. In so doing, however, the committee does not intend to disrupt established procedures for billing for health care services or established employment arrangements between health care practitioners.

More specifically, it is the committee's intent that direct access shall not lead to a disaggregation of fees now charged for health care services under the FEHBP. In the case of a health care provider who is employed by another health care provider, for example, H.R. 4825 does not encourage the employed health care provider to submit separate charges for his or here services, if those charges would otherwise be included in the employing provider's fees. Such disaggregation of fees does not reflect an increase in freedom of choice for patients; it simply represents an increase in the number of bills submitted for the same health care.

Many FEHBP fee-for-service plans already provide for direct access to one or more types of qualified non-physician health care providers. Furthermore, as noted earlier, all such FEHBP plans have been required to offer direct access to qualified psychologists and optometrists since 1973. It is the committee's belief that from this experience, these FEHBP plans have established procedures to discourage disaggregation of billing. Consequently, the amendment to section 8902(k) of title 5, requires that the terms and conditions governing payments or reimbursement to chiropractors, qualified

clinical social workers, marriage and family therapists, nurse midwives, nurse practitioners, and any other nurses shall be the same as the terms and conditions generally applicable under contracts requiring payments or reimbursements for services of clinical psychologists and optometrists.

Section 1(b) of H.R. 4825 expresses Congressional intent with respect to the effects of mandatory direct access to certified registered nurse anesthetists (CRNAs). Because of the relatively unique aspects of the method by which anesthesia services are provided, H.R. 4825 deals separately with the issue of direct access to CRNAs.

Direct reimbursement for anesthesia services is mandated under H.R. 4825 when a contract requires payment or reimbursement for anesthesia services. H.R. 4825 provides that beneficiaries shall be free to select and utilize the services of nurse anesthetists subject to requirements of state law and of applicable hospital by-laws or rules governing supervision and direction of CRNAs. The laws of most, if not all, States require physician supervision of nurse anesthetist services and the rules of many hospitals require the delivery of anesthesia care under an anesthesia care team method involving both anesthesiologists and CRNAs. The committee intends that the same limitations will apply with reference to outpatient and ambulatory facilities in which anesthesia services are provided.

Testimony relating to H.R. 4825 indicates that most self-employed nurse anesthetists render care in rural settings or in small community hospitals, often under the supervision of a surgeon or obstetrician. Just as the committee wishes to make possible direct access to the services of these nurse anesthetists to plan beneficiaries, it also wishes not to interfere with state law or regulations, or those rules or regulations adopted or authorized by the institution in which the services are performed, relating to the type and extent of medical direction required in this context.

Furthermore, the committee does not intend to interfere with the employment agreements pursuant to which most nurse anesthetists perform their services, either as employees of a hospital or of a physician or physicians' group. Reference is thus made in the bill to a "self-employed" nurse anesthetist, that is, one who is not so employed but is rather offering his or her services as an individual or as a member of a professional corporation.

EXEMPTION FOR PREPAID, COMPREHENSIVE HEALTH PLANS

Under current law, comprehensive prepayment group practice health insurance plans are exempt from FEHBP requirements mandating direct access to certain non-physician health care providers.

The committee recognizes that comprehensive prepayment plans, whether of the group practice, individual practice, or mixed model, constitute a system of health care delivery and financing which is different from fee-for-service health care. The emphasis on prevention, comprehensive care, and managed utilization of health services characterizes the prepaid health care sector and contributes greatly to its cost control successes and patient satisfaction. Pre-

paid plans employ or contract with their health care providers to offer comprehensive services to enrollees in return for a fixed fee.

While the prepaid sector has broadened beyond group practice plans to include the individual practice and mixed model plans, it has retained this basic structure and philosophy throughout all plans. The committee believes this structure and philosophy have contributed greatly to the success and viability of such plans within the FEHBP. Requiring that prepaid plans provide their enrollees direct access to outside providers, therefore, would be inconsistent and inappropriate, and would undermine the viability and cost-effectiveness of such plans.

Consequently, the amendment to section 8902(k) of title 5 specifies that the direct access requirements shall not apply to prepayment plans described in section 8903(4) of title 5. The committee firmly believes there is no contradiction in promoting direct access to non-physician health care providers under fee-for-service plans while maintaining the status and operation of prepaid health plans in the FEHBP. Direct access under fee-for-service plans will promote cost savings and better health care, as will the continued success of prepaid, comprehensive health plans.

At the same time, the committee also believes that excluding non-physician health care practitioners from prepayment plans could limit access to a wide range of health services within those plans. Further, the committee recognizes the potential cost savings that prepaid plans could attain by fully utilizing non-physician health care providers. The committee notes that concerns have been raised by the American Psychological Association regarding the mental health services and providers made available to enrollees in various prepaid plans, especially the individual-practice and mixed-model plans. The committee also is aware of concerns which have been raised by the American Psychological Association about the potential for these plans to limit access to non-physician health practitioners, which could have adverse implications for the delivery of mental health services in particular, and for non-physician health practitioners, such as psychologists, who are qualified to deliver mental health services. The committee intends to monitor the functioning of individual practice and mixed model plans very closely. The committee encourages all types of prepaid plans to utilize non-physician health practitioners, especially those recognized for direct reimbursement in the FEHBP.

COORDINATION OF DIRECT ACCESS REQUIREMENTS AND OTHER COST-CONTAINMENT EFFORTS

The committee is convinced that expanding access to qualified health care practitioners will encourage all providers to charge competitive fees under the FEHPB. At the same time, however, the committee does not intend for the direct access requirements in H.R. 4825 to interfere with or prevent the development of other cost-containment efforts within the program.

For example, the inclusion in a FEHBP carrier's contract of economic incentives for beneficiaries to select particular physicians or non-physician practitioners should not be construed as an infringe-

ment on an individual's freedom of choice and is not intended to be prohibited by H.R. 4825.

Furthermore, the requirement of a carrier for a second opinion as to the medical necessity for a particular procedure or service under the contract or the application of exclusions or limitations contained in the contract, other than those specifically prohibited by law, should not be construed as an infringement of an individual's freedom of choice of a provider and is not intended to be prohibited.

Section Analysis

Section 1(a) of the bill consists of several amendments to section 8902(k) of title 5, United States Code.

Paragraph (1) of section 1(a) amends paragraph (1) of section 8902(k) by inserting new language providing that FEHBP participants shall have direct access to clinical psychologists or optometrists, licensed or certified as such under Federal or State law, as applicable, without supervision or referral by another health practitioner, except if, or to the extent that, any such supervision or referral is required under State or local law, or any regulation issued thereunder, which relates to licensing or certification to practice medicine, nursing, or another health profession.

Paragraph (2) of section 1(a) amends section 8902(k) by redesignating paragraphs (2) and (3) of such section as paragraphs (3) and (5), respectively.

Paragraph (3) of section 1(a) amends section 8902(k) by inserting a new paragraph (2).

Subparagraph (A) of the new paragraph (2) provides that FEHBP participants shall be free to select, and shall have direct access to, certain health practitioners without supervision or referral by another health practitioner except if, or to the extent that, any such supervision or referral is required under State or local law, or any regulation issued thereunder, which relates to licensing or certification to practice medicine, nursing, or another health profession.

Subparagraph (B) of the new paragraph (2) provides that subparagraph (A) applies with respect to a chiropractor; a qualified clinical social worker, as defined by section 8901(11)(A) of title 5; a marriage and family therapist; and a nurse midwife, nurse practitioner, and any other nurse, provided such health practitioner is licensed or certified as such under Federal or State law, as applicable.

Paragraph (4) of section 1(a) amends redesignated paragraph (3) of section 8902(k) to clarify that, except as may be required by State licensing or certification laws or regulations, FEHBP contracts may not, as a condition for payment or reimbursement, require that the services of a qualified clinical social worker who is licensed or certified as such by the State in which such individual practices be performed pursuant to a referral by a psychiatrist.

Paragraph (5) of section 1(a) amends section 8902(k) by inserting a new paragraph (4) after redesignated paragraph (3). The new paragraph (4) provides that when a contract under chapter 89 of title 5, United States Code, requires payment or reimbursement for services of a chiropractor, qualified clinical social worker, marriage

and family therapist, nurse midwife, nurse practitioner, or any other nurse, the terms and conditions governing such payments or reimbursements shall be the same as the terms and conditions generally applicable under contracts under such chapter 89, requiring payments or reimbursements for services of a clinical psychologist or optometrist.

Paragraph (6) of section 1(a) amends redesignated paragraph (5) of section 8902(k) to provide that the direct access provisions of section 8902(k), as amended by the bill, shall not apply to prepayment plans described in section 8903(4) of title 5.

Section 1(b) of the bill expresses the intent of Congress that nothing in the amendment made by section 1(a) of the bill shall interfere with applicable institutional anesthesia practice rules, or State or local law, governing supervision of a certified registered nurse anesthetist by another health practitioner; and that such amendment, as it relates to a certified registered nurse anesthetist, shall apply only with respect to a certified registered nurse anesthetist who is self-employed and licensed or certified under Federal or State law, as applicable.

Section 1(c) of the bill provides that regulations or instructions issued to carry out the amendments made by section 1(a) of the bill shall reflect the statement of congressional intent set forth in section 1(b).

Section 2 of the bill consists of several amendments to section 8902(m) of title 5, United States Code.

Paragraph (1) of section 2 amends section 8902(m) by redesignating paragraph (1) as paragraph (1)(A).

Paragraph (2) of section 2 amends section 8902(m) by adding a new subparagraph (B) at the end of paragraph (1)(A). The new subparagraph (B) provides that nothing in chapter 89 of title 5 nor in the provisions of any contract under chapter 89 shall be considered to supersede or preempt any State or local law, or any regulation issued thereunder, which relates to licensing or certification to practice medicine, nursing, or another health profession.

Paragraph (3) of section 2 amends the last sentence of paragraph (2)(A) of section 8902(m) to provide that in applying paragraph (2) of section 8902(m) with respect to a qualified clinical social worker described under section 9801(11)(B) of title 5, any provision of a contract relating to the condition described in section 8902(k)(3)(A) shall not be considered.

Section 3 of the bill provides that the amendments made by the Act shall be effective with respect to contracts entered into or renewed for calendar years beginning after the date of the enactment of the Act.

COST

The cost estimate prepared by the Congressional Budget Office pursuant to sections 308(a) and 403 of the Congressional Budget Act of 1974 is set forth below.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC., July 23, 1986.

Hon. WILLIAM D. FORD,
Chairman, Committee on Post Office and Civil Service,
U.S. House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: As you requested, we have reviewed H.R. 4825 as ordered reported by the Committee on Post Office and Civil Service on June 11, 1986. Based on our analysis, we estimate that enactment would have no significant impact on the federal budget. The budgets of state and local governments would not be directly affected.

H.R. 4825 grants authority for insurance carriers to make direct payments to certain health professionals under the Federal Employees Health Benefits (FEHB) program, subject to state laws licensing and regulating the practice of health care. The level and type of health benefits covered under FEHB plans will continue to be negotiated between the Office of Personnel Management and insurance carriers, and would not be altered by this legislation.

This bill would allow enrollees to have direct access to qualified nurse midwives, nurse practitioners, clinical social workers, chiropractors, and marriage and family therapists when an insurance carrier covers services which may be performed by such health practitioner and such health practitioner is licensed or certified under applicable state or local law. In addition, direct access to nurse anesthetists shall be authorized so long as it does not affect the operation of established anesthesia care teams in hospitals or other surgical settings. Direct access to these health practitioners would not apply to prepayment plans such as health maintenance organizations because of their unique procedures for providing and financing care.

In March 1986, the Office of Personnel Management (OPM) published a study on the feasibility of direct access to certain health practitioners under FEHB. The OPM study concluded that many insurance carriers already offered direct access to non-physician providers and, furthermore, that a program-wide policy of direct access would not reduce the quality of care or increase costs in FEHB. Based on this study, we estimate that direct access to these health practitioners would not result in increased costs so long as the level and type of health benefits are designed by insurance carriers and states continue to regulate the licensing and practice of health professionals.

If you have any questions please call me or your staff may wish to contact Anne Manley (226-2820).

With best wishes,

Sincerely,

RUDOLPH G. PENNER, *Director.*

OVERSIGHT

Under the rules of the Committee on Post Office and Civil Service, the Subcommittee on Compensation and Employee Benefits is vested with legislative and oversight jurisdiction over the subject matter of this legislation. As a result of the hearings, the subcom-

mittee concluded that there is ample justification for enacting this legislation.

The committee received no report of oversight findings or recommendations from the Committee on Government Operations pursuant to clause 4(c)(2) of House Rule X.

Inflationary Impact Statement

Pursuant to clause 2(l)(4) of House Rule XI, the committee has concluded that the enactment of H.R. 4825 will have no inflationary impact on the national economy.

Changes in Existing Law Made by the Bill, As Reported

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 5, UNITED STATES CODE

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PART III—EMPLOYEES

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Subpart G—Insurance and Annuities

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CHAPTER 89—HEALTH INSURANCE

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§ 8902. Contracting authority

(a) * * *

* * * * * * *

(k)(1) When a contract under this chapter requires payment or reimbursement for services which may be performed by a clinical psychologist or optometrist, licensed or certified as such under Federal or State law, as applicable, an employee, annuitant, family member, or former spouse covered by the contract shall be free to select, and shall have direct access to, such a clinical psychologist or optometrist without supervision or referral by another health practitioner *(except if, or to the extent that, any such supervision or referral is required under State or local law, or regulations issued thereunder, as described in subsection (m)(1)(B))* and shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed.

(2)(A) When a contract under this chapter requires payment or reimbursement for services which may be performed by a health practitioner referred to in subparagraph (B), an employee, annuitant, family member, or former spouse covered by the contract—

(i) shall be free to select, and shall have direct access to, such a health practitioner without supervision or referral by another health practitioner (whether of a type referred to in subparagraph (B) or otherwise), except if, or to the extent that, any such supervision or referral is required under State or local law, or regulations issued thereunder, as described in subsection (m)(1)(B); and

(ii) shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed.

(B) This paragraph applies with respect to—

(i) a chiropractor;

(ii) a qualified clinical social worker, as defined by section 8901(11)(A) of this title;

(iii) a marriage and family therapist; and

(iv) a nurse midwife, nurse practitioner, and any other nurse;

who is licensed or certified as such under Federal or State law, as applicable.

[(2)**]** *(3)* When a contract under this chapter requires payment or reimbursement for services which may be performed by a qualified clinical social worker, *as defined by section 8901(11)(B) of this title*, an employee, annuitant, family member, or former spouse covered by the contract shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed. **[**As**]** *Subject to subsection (m)(1)(B), as* a condition for the payment or reimbursement, the contract—

(A) may require that the services be performed pursuant to a referral by a psychiatrist; but

(B) may not require that the services be performed under the supervision of a psychiatrist or other health practitioner.

(4) When a contract under this chapter requires payment or reimbursement for services of a health practitioner covered by paragraph (2) or (3), the terms and conditions governing such payments or reimbursements shall (except to the extent otherwise permitted under paragraph (3)(A)) be the same as the terms and conditions generally applicable under contracts under this chapter requiring payments or reimbursements for services of health practitioners covered by paragraph (1).

[(3) The provisions of this subsection shall not apply to group practice prepayment plans.**]**

(5) The provisions of this subsection shall not apply to prepayment plans described in section 8903(4) of this title.

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(m)(1)*(A)* The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

(B) Nothing in this chapter nor in the provisions of any contract under this chapter shall be considered to supersede or preempt any State or local law, or any regulation issued thereunder, which re-

lates to licensing or certification to practice medicine, nursing, or another health profession.

(2)(A) Notwithstanding the provisions of paragraph (1) of this subsection, if a contract under this chapter provides for the provision of, the payment for, or the reimbursement of the cost of health services for the care and treatment of any particular health condition, the carrier shall provide, pay, or reimburse up to the limits of its contract for any such health service properly provided by any person licensed under State law to provide such service if such service is provided to an individual covered by such contract in a State where 25 percent or more of the population is located in primary medical care manpower shortage areas designated pursuant to section 332 of the Public Health Service Act (42 U.S.C. 254e). [This paragraph shall apply with respect to a qualified clinical social worker covered by subsection (k)(2) of this section without regard to whether such contract contains the requirement authorized by clause (i) of the second sentence of subparagraph (A) of such subsection (k)(2).] *In applying this paragraph with respect to a qualified clinical social worker under section 8901(11)(B) of this title, any provision of a contract relating to the condition described in subsection (k)(3)(A) of this section shall not be considered.*

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